



Health Committee

Oral evidence: [2015 accountability hearing with the General Dental Council](#), HC 1110

Wednesday 11 March 2015

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Written evidence from witnesses:

- [General Dental Council](#)

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Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Andrew George, Robert Jenrick, Charlotte Leslie, Grahame M. Morris, David Tredinnick

Questions 1-121

Witnesses: **Dr William Moyes**, Chair, and **Evlynne Gilvarry**, Chief Executive and Registrar, General Dental Council, gave evidence.

Q1 Chair: Good morning. Thank you for coming to our accountability hearing. For those who are following this outside, would you mind introducing yourselves?

Evlynne Gilvarry: My name is Evlynne Gilvarry. I am the chief executive of the General Dental Council.

Dr Moyes: I am Dr William Moyes. I am the chairman of the General Dental Council.

Q2 Chair: Thank you. Perhaps I could cut to the chase and say that we have heard a lot of evidence that dentists in Britain have lost confidence in the GDC as their professional regulator. Could you comment on that and set out what your strategy is to try to put that right?

Dr Moyes: Perhaps I can kick off and then Evlynne can pick up. We are very clear that the GDC's prime responsibility is to protect patients and, although various surveys show that overall there is quite a decent level of patient satisfaction with dentistry, when you go into the light and shade there is quite a bit of dissatisfaction among certain groups. Some people feel sufficiently dissatisfied—13,000 of them in fact—to write to a national body. We are very keen to make sure that, working with the profession, we have a system that does protect patients.

The new council, which took office in October 2013, has four priorities at the moment to that end. First, we know that the GDC's performance has to be improved, and we have known that from quite early on in our time and have invested quite a lot of time and money in tackling some immediate issues with fitness to practise. We think that the investment that we have made is beginning to pay off. We are seeing cases treated faster, unit costs falling and the backlog of cases that had built up almost completely eliminated. We are now conducting a much more thorough review of our fitness to practise process to try to squeeze out efficiencies. Across the organisation as a whole we have launched a major change programme to try to change the way it works, things like linking pay to performance and not length of service, and doing proper programmes of leadership and management development. We are reviewing our governance function. We are reviewing communications and legal functions.

Q3 Chair: To be fair, Dr Moyes, that was not the question I asked you, and we are going to come to all those points in detail later on. The question I asked you was on the issue of loss of confidence from the profession, and your response seemed to indicate that that was inevitable because patients were writing in to complain. Does it concern you that there appears to be a loss of confidence from the profession?

Dr Moyes: I was trying to address the question I thought you asked, which was what our strategy was for regaining confidence.

Q4 Chair: Okay, but the wider comment is an important one. Does that concern you?

Dr Moyes: It does concern me up to a point, but some of the loss of confidence is perhaps based on misconceptions about the real role of the GDC. One thing we discovered when we consulted on increasing the annual retention fee is that many registrants assumed that the role of the GDC was to support the profession. We have to be fair to the registrants who end up in our fitness to practise process, but our prime legal responsibility is to protect patients, and our strategy is to try to create an organisation that protects patients efficiently and effectively, communicates well and runs itself cost-effectively—cost-efficiently.

Evlynne Gilvarry: If I may add to that, when we talk about the dental profession it is a great deal larger than just dentists. Dentists make up the smaller proportion of it. It is 40,000 dentists and 60,000 dental care professionals, so when we talk about confidence levels we need to not miss that point. Certainly the confidence levels of dentists, as expressed to us last year, were lower than we had previously noted in our polls. The previous year we did a poll which showed 70% confidence levels across the profession overall. Last year was a very difficult and troubled year when, albeit after four years, we had to go to the profession for a rise of 55%. That was something hard for the dental profession to take on board—as you know, dental care professionals had a discount last year—so it was a very particular year. This year we are going out of our way to build confidence with the profession in a number of ways. We are keen to make a partnership with the profession to help, first of all, to get a better shared understanding of our objectives, to correct misapprehensions about the way we regulate and to ensure that they

come along with us in enforcing our new standards, which is important to us—a very important part of our work.

Q5 Chair: Can I be clear? Are you implying that there is no loss of confidence from dental care professionals? You see this as being entirely a loss of confidence from dentists.

Evlynne Gilvarry: The polls that showed loss of confidence last year were undertaken by the dentists' trades union. There were no parallel polls taken by dental care professionals. I am not assuming that their confidence levels are optimum, but we have no reason to suspect otherwise. During the consultation on the ARF last year we did not get the volley of criticism or expressions of dissatisfaction from dental care professionals that we did from dentists.

Q6 Chair: Dr Moyes, you were starting your list. Do you want to complete that list?

Dr Moyes: The things I would like to register briefly, if I may, are first of all, yes, a lot of effort is going into improving performance, with results coming through, but audit-type processes are not picking that up yet, because they naturally look backwards. We are not sitting complacently. We are working very hard to make the GDC a different organisation.

The second point to register is the extent to which changing our processes is not under our control. If we want a better fitness to practise process, we have to get some legislative changes. It is disappointing that that is not going to happen in this Parliament, but it will happen, I think, in time.

Chair: Hopefully, we can give you an opportunity later on to set out what those measures would be. I am going to come to my colleague, Andrew George.

Q7 Andrew George: Thank you. On that point, it seems from the evidence we have been given that the BDA's General Dental Practice Committee, the BDA's UK Council, the BDA's English Council, the Conference of Local Dental Committees, the Scottish Dental Practice Committee and a whole host of others, including regional committees, have expressed no confidence in the GDC. Has anyone any confidence in you?

Dr Moyes: Lots of people have confidence in us. Patients have confidence in us. As Evlynne said, non-dentist dental care professionals have a very good relationship with us. Dental schools, which we inspect, have a very good relationship with the GDC. We had a meeting about a month ago to which we invited local dental committees, dental schools and others, and the faculties, and we had a very productive discussion with them and got very good feedback. It is not true to say that the loss of confidence is absolutely universal. As Evlynne said, last year was an odd year. It is not often that a body like ours asks for such a big increase in fees, but after four years of zero increase and the reserves being eaten up it is not surprising that we needed it. But I would not take 2014 as a typical year at all.

Q8 Andrew George: Clearly you can point to the increase in the fee, but are you saying that it is entirely down to that and nothing else?

Dr Moyes: There is a feeling in some parts of dentistry—I think it is dentistry rather than dental care professionals—that too many cases end up in the fitness to practise process, and we agree with that. One of the things we like to do is to develop an intermediate system, if you like, so that cases which cannot be resolved in the practice by discussion between the patient and the dentist, but are not at the most serious end of cases, can be resolved by some kind of regional mechanism. We have the Dental Complaints Service, which does that for privately funded dentistry; it does it efficiently and quickly and is very popular with registrants and patients. We would like to see that kind of conciliation system—not a quasi-judicial system—become part of a three-level complaints resolution system: the practice, the Dental Complaints Service-type machinery and then fitness to practise.

Q9 Andrew George: Clearly we would all accept that it would be worrying if the profession itself had a cosy hand-in-glove relationship with the GDC, but don't you think that the current state of affairs is unsustainable? The profession themselves of course want to protect their interests—one can understand that—but the degree of lack of confidence must be something you cannot dismiss lightly. It does not happen in many other professions.

Dr Moyes: I am not dismissing it lightly; it is something that the council and I discuss regularly. We are aware that in the past we have communicated very badly. That is one of the reasons why we are reviewing completely the way we communicate, what we communicate and how transparent we are. One of the things we will certainly do is publish much more information about how fitness to practise is operating, because there are a lot of misconceptions about that and about the kind of cases that get into fitness to practise. There is a big communications effort for us, and that will go some way towards tackling the genuine loss of confidence that there is from some parts of dentistry—but I stress dentistry. To come back to a point I made earlier, some of our problems are not within our control. We have to get some legislative change to bring our practices up to the level of the GMC, for example; we are 10 years behind.

Q10 Andrew George: But it is not just legislation. You have been taken to judicial review, and the BDA have criticised your organisation for the high-handed and dismissive way you reacted to the outcome. They have also criticised you for being too secretive, having too much of your activity and council discussions increasingly taking place in private, and they do not believe that that is justifiable. It is not just a question of the fee and the nature of the relationship. There is a whole set of other things. You will be aware of the litany of criticisms that Sir Paul Beresford described in a debate on 9 December last year. Those criticisms have been strongly echoed across the profession.

Dr Moyes: There are three points there. On the judicial review, when you unpick the judgment, the judge actually criticised us for missing out one step in the argument. He said that the impact is so small on individual dentists that we did not really have to consult but we chose to consult, and he gave us credit for that. But he then said that having chosen to consult, and created the expectation of a comprehensive consultation, the step we missed out in the argument was to make the link between an expected growth in the number of

complaints and the number of hearing days, which is one of the drivers—but only one—of our cost. That is what it comes down to. It is a lesson we have learned. We did not think that that level of arithmetic detail would be appropriate. The judge found it was, but he did not quash the regulations, he did not tell us to re-consult and he did not tell us to redo our annual retention fee collection. He simply made that comment. That is one point I would make.

Q11 Andrew George: And the sitting in private?

Evlynne Gilvarry: One of the features of last year that was, one could say, positive was that the profession became aware in a way that it had not previously been—which may have been our failure—of the extent of complaints coming to us and, correspondingly, the rather complicated procedures we have to apply to deal with those complaints. Through an accident of history, the General Dental Council's legislation is very much more outdated than some of the other larger regulators. That is something we have to deal with. It was something we were dealing with well enough when our case load was 1,500 a year, as it was when I joined the organisation, but within three years that had ballooned by 100%. For the first two years we did not say very much about that. We got on with it as best we could, using our reserves to fund the additional resources—probably not enough in hindsight—to deal with it, but there came a point when that was no longer tenable. We had to go to the profession and ask them for, yes, a very large amount of money, and in the course of that we put a lot of information out there to explain our case.

Although there was that key missing bit from the judgment which caused the judge to say that overall our consultation was not lawful, we put an awful lot of information out there, and the effect of that was to shine a real light on our fitness to practise processes, on the degree of complaints. The feedback we started to get from the profession also made it very clear to us that there were some fundamental misunderstandings on the part of the profession—probably again we must take responsibility for this—as to the nature of our fitness to practise process. We were getting a lot of charges along the lines of, “You’re accepting trivial complaints that should not be entertained at all.” Not true, but that was the perception.

From here on in—and we have already started this year—we would like to do our very best to try to demystify, to explain as well as we can the fitness to practise processes that we operate. We are improving ourselves. We have no illusions about the amount of improvement in our own performance, and that is happening, but in addition we need a partnership with the profession and a shared understanding of the systems within which we operate.

Just in case you think we are sitting back and saying there is nothing we can do about it because we have this outdated legislation and we still do not have any improvements, that is not so. We are working in partnership with NHS England—I will come on to Scotland in a moment—on five pilot programmes to look at how certain categories of cases can be handled better under the NHS performance management framework. The pilot will run for the whole of this year and the findings from that ought to produce rich information that will allow us to develop a national scheme. We are also having discussions with our colleagues in Scotland to roll out similarly. We hope to ensure as a result of those pilots that a greater number of cases that necessarily are coming to us now might be handled on

the ground through local resolution. I hope that sends a signal to the profession that we are earnest about better, more proportionate complaints handling, and we are not just sitting here wringing our hands saying there is nothing we can do. We are of course hopeful that we will get legislative change.

Q12 Chair: Do you regret the tone of the press release you put out after the court judgment, which was very defensive and dismissive and described it as a procedural error, and then just reminded people that they had a few weeks to pay? Do you think, on balance, that that was a good way of rebuilding the confidence of the profession? Do you think it was unfortunately worded?

Evlynn Gilvarry: That has already been acknowledged by the chairman. The tone and nature of our communications have not been perfect and, yes, there have been lessons to be learned from our communications generally. We have a plan to be better on that. There was no arrogance intended. The whole JR experience was not easy for the organisation. There was certainly no high-handedness or arrogance intended in that press release. We were simply putting information out there from our side, from our point of view.

Dr Moyes: Could I add one point, if I may? The context, as well, was quite a lot of chatter on social media about different ways in which payment could be made that would frustrate; it could be withheld or paid in pennies, or paid by some mechanism that we could not handle. We were trying to say, not very elegantly, to dentists, “Do remember, if you’re not on the register, you cannot practise dentistry.” Perhaps we should have said it differently, but we were just trying to make a point to people: “If you are thinking of withholding or doing something that means you will not have paid your fee by the due date, there are consequences, and there are legal systems that we cannot ignore.” That was part of the context.

Chair: That was the purpose.

Q13 Robert Jenrick: Following up on the comments and questions from my colleagues, do you think it would be better for the reputation of the organisation if you considered your positions? Do you think you are the right individuals to lead forward what is an important body, given the mistakes you admitted making, the poor communication and the clear loss of confidence of at least one key sector of your organisation—dentists?

Dr Moyes: I do not think there are any grounds for asking that question. We took up office in October 2013, a new council—a smaller council. I am the first lay chairman. I do not see any grounds whatsoever for saying that we are not tackling vigorously the problems that we inherited. We are tackling them very vigorously and the results are coming through and—

Q14 Robert Jenrick: But you have tacitly admitted that you do not have the support of dentists. If you do not have the support of dentists, how can you continue in your role?

Dr Moyes: The BDA represents less than half of dentists. We may not have the vocal support of the BDA, but I am not prepared to accept the proposition that all dentists

uniformly are antagonistic towards the GDC. I do not believe that to be true. I will accept that our communications and organisation have been weak. One of the things the council wants to do is to strengthen it. But I know from a lot of experience in other sectors that before you can do lots of things you have to get your finances into shape. That was an absolute priority for 2014. We were going bust.

Q15 Robert Jenrick: Could I ask the question of your colleague? You have been at the helm of this organisation for—

Evlynne Gilvarry: For four years, during which—

Q16 Robert Jenrick: During the years when you chose not to levy more money, which you now claim is one of the reasons why you had to levy so much in 2014, you cannot make the reasonable suggestion that you only came in to sort out the mess, because you were there during those years. Do you think you as an individual are suitable to continue?

Evlynne Gilvarry: Let me explain about those four years. First of all, our primary driver of cost is our case load—our fitness to practise case load. When I joined, we had 1,400 cases a year. Within a very short space of time, that doubled. We did our very best, because we had some reserves, to use those reserves to fund the additional work load. We were also going through a massive change programme, because when I joined a very big change programme was required—a big programme of improvement—so we were getting on with that. Nothing in the pattern of previous complaints had prepared us for the explosion over three years—nothing. If you look at the pattern over the previous 10 years, it was modest growth every year; so, frankly, yes, we had not anticipated that the complaints would grow that far. The organisation had to double in size within a very short space of time.

Also, in relation to the annual retention fee and its level, we were operating in a climate where the Department of Health—the Government—was making it plain that regulators should not, if at all possible, unless there was the strongest business case, raise the cost of regulation. This was set out in a Command Paper three years ago. We listened to that very carefully. At the same time, the Department was saying, “And to help you streamline, because we know you are operating rather expensive systems”—they said this to all the regulators—“we will introduce this Bill.” They asked the Law Commission to start working on that Bill. We were travelling forward with optimism. We used our reserves—we did not reduce them below a prudent level—so at the point in late 2013 when it started to look like we could no longer go any further, we had to plan for an ARF increase and we did it assiduously.

We first of all decided that we would consult on the policy, the underlying principles, to be applied in raising the ARF, so that we would go about it with complete transparency and fairness. The consultation on the level of the fee was preceded by a lengthy consultation on the principles that would underline that. Arising from the initial consultation, the council agreed that the cost of regulation should relate directly to the group within the profession that was accountable for that cost—in other words, in this case, dentists: 90% of fitness to practise cases relate to dentists. When we went out to consultation on the level of the fee, we did so on the basis of our best estimate at that time. The original estimate of the fee was larger than we eventually agreed, because we were

able to recalibrate our fees as we went through the consultation exercise. To answer your question, we are getting on with it. We have had to work hard in an organisation that necessarily had to expand very rapidly. We did not get everything right, but we are absolutely determined to put the organisation on a steady stream from here on in.

Chair: Rosie has one tiny follow-up point, and then we will go on to Grahame.

Q17 Rosie Cooper: I have been doing some reading. You said that there was an explosion of complaints, yet the stuff I have just been reading suggests that you took out quite a dramatic and hard advertising campaign to encourage people to complain. Therefore, perhaps you should not be surprised at the doubling of complaints. I am one of those who believes that if patients have a complaint, they should be heard, but I find a mismatch with the advertising and then the surprise that you got a lot more complaints.

Evlynne Gilvarry: I understand. Let me explain. That advertisement was for a different service. We run the statutory fitness to practise process and then a non-statutory conciliation scheme to handle complaints that do not raise matters of fitness to practise and arise out of treatment in private dentistry. It is a very different service—the Dental Complaints Service that the chairman referred to a little earlier. The kind of complaints the service deals with are poorly-fitting dentures, mispricing, perhaps, of treatment, treatment that did not go quite right—that sort of thing—all privately paid for. The conciliation service does not deal with complaints that raise matters of fitness to practise. If the Dental Complaints Service receives a complaint that suggests an allegation of fitness to practise or impaired fitness to practise, they immediately refer it to our fitness to practise processes. The explosion of complaints that I talked about was coming into our fitness to practise processes. Actually, you could argue—and it is true—that the Dental Complaints Service stops the further clogging up of our early triage process with complaints that for private dentistry are better going to the DCS. They were different operations.

Rosie Cooper: I understand the—

Chair: We are coming to that a bit later as well, Rosie. Grahame?

Q18 Grahame M. Morris: Thank you, Chair. You have covered some of the ground and we have limited time, so I am not going to repeat the questions, but would it be reasonable to say that you have some responsibility in not anticipating that the lack of detailed financial information within the consultation following the judicial review and the decision would leave the GDC open to a legal challenge? Shouldn't you have anticipated that?

Dr Moyes: We put quite a lot of information in the consultation. I can talk in a second about the detail if you would like to hear it. There was simply one piece of arithmetic that we did not put in, which is something that links the rise in the number of complaints coming in with the number of hearings. The number of hearing days is one driver of our cost and we did not expose the arithmetic there—that is the point—but if one looks at the consultation document, there is a lot of information about finances and there are options canvassed in there.

Q19 Grahame M. Morris: Leading on from that, could you explain why the GDC expected the conversion rate from complaints to fitness to practise hearings to increase substantially—by 116%—this year? What factors in particular caused you to anticipate that increase?

Evlynne Gilvarry: There is one key one. During 2014 we had a backlog of 750 cases. We have now cleared the backlog through the initial investigation stages. A proportion of those will need to go to a hearing—about 10%—so, in addition to the regular case load, there are a further 10% coming through. What we are looking at is a wave of cases coming through, and the higher estimate for hearings in 2015 directly related to our need, our desire, to clear those cases through the staging of extra hearings. We are now running eight hearings every day. In the past, we were running three or four. The extra hearings this year are to make sure that we do not get behind, that we meet our KPIs for time limits.

Q20 Grahame M. Morris: I appreciate that. Just to clarify, is the additional revenue raised by the increase in the retention fee being used specifically to fund the additional case load to address the backlog? What is it being used for specifically?

Evlynne Gilvarry: It is being used for that purpose.

Q21 Grahame M. Morris: A hundred per cent of it is used for that purpose.

Evlynne Gilvarry: No. It is being used for that purpose, but in addition it is being used to enable us to be able to deal with what is now a very large case load. We have over 3,000 cases a year, and that, within our current systems, is an expensive case load to keep going through at the pace that we need to meet our KPIs at each stage.

Dr Moyes: We also have to rebuild our reserves; do not ignore that.

Q22 Grahame M. Morris: With all due respect, I had quite a lengthy period in local government and I know there are many pressures facing large organisations, and rebuilding reserves, I would suggest, is perhaps not a significant one, but in terms—

Dr Moyes: I don't agree—

Q23 Grahame M. Morris: Please. In terms of anticipating demands, because you are at the helm of the ship, could you reasonably have anticipated, going back to 2011, this increase in the number of complaints that would be translated into fitness to practise hearings and therefore incrementally increased the fees in a staged way, rather than have such a dramatic increase?

Dr Moyes: That is really a question for the previous council, if I may say so, because their policy, for whatever reason, was not to increase the fees. My own view now, and the council's view now, is that, going forward, we will look at the ARF every year in some detail and if the pattern of complaints, and the conversion rates, look as though an increase

or a decrease in fees can be justified, adjusting the ARF should be an annual process, rather than waiting until there has to be a cataclysmic increase.

Evlynne Gilvarry: As you would expect, we have looked very closely at our forecasting methods. I mentioned a little earlier that there was nothing in the previous decade that prepared us for this explosion over a very short space of time, but we are taking nothing for granted from here on in. We have a new forecasting model—an 18-month rolling forecasting model—which we will publish, and make sure that the information is in the public domain. That of course will be our management tool to enable us to do an annual review of the annual retention fee to decide whether or not it needs to be adjusted in any one way or another.

Chair: Thank you.

Q24 Rosie Cooper: Your evidence suggested that the GDC has cleared your backlog of cases. Overall, how many cases do you now have awaiting a decision by the investigating committee or a fitness to practise hearing?

Evlynne Gilvarry: We have cleared the backlog of 750 cases through the initial investigation stages. Some of them are queued for an investigating committee hearing, and, as I mentioned to your colleague, about 10% of those will be queued for a final hearing, so they are not completely through the system yet. The vast majority of cases coming into triage—we have an initial triage stage—are now cleared within the KPI of 10 days. A significant proportion—I think about 65% or 70% of cases—are meeting the six months to an IC hearing, the investigating committee hearing, and then a similar proportion are meeting the KPI for referral from the investigating committee to a fitness to practise committee. That is not a perfect record, but we are seeing improvements, a shortage in the median time taken, every month we go forward. We are monitoring it very carefully.

Q25 Rosie Cooper: The question was: “How many?”

Evlynne Gilvarry: I will have to get you the figures on that; I do not have them immediately to hand.

Q26 Rosie Cooper: A really important part of the story is the backlog—where you are up to—but you do not know how many you have in the pipeline; you do not know where you are; you can tell me percentages, but you cannot tell me how many.

Evlynne Gilvarry: I can tell you that the backlog of 750 cases has been cleared through the initial stages.

Q27 Rosie Cooper: Through one stage.

Evlynne Gilvarry: Yes.

Q28 Rosie Cooper: How many of those are cleared, or are all 750 still in the rest of the stages? How many others have been added? What is the current state of play?

Evlynne Gilvarry: They will all be through by April to the investigating committee and a further—

Q29 Rosie Cooper: What is the current state of play? That is the question.

Evlynne Gilvarry: About 10% of those will be still going through.

Q30 Rosie Cooper: Ten per cent of what?

Evlynne Gilvarry: Ten per cent of 750.

Q31 Rosie Cooper: So you do not have any more than 750. That is it. You just have 750 complaints, or are you just talking about the backlog? Where are you up to today?

Evlynne Gilvarry: You asked me about the backlog. I am talking about the backlog, which is 750. That is on top of the steady state—

Q32 Rosie Cooper: Can I read you what I said? Your evidence said you had cleared the backlog, but how many cases overall do you still have awaiting decision by either the investigating committee or a fitness to practise hearing? Is that the 750? Have you not had any more? Where are you up to?

Evlynne Gilvarry: We have been focusing on the backlog, with the 750, most of which are clear, as I said, but we have an inventory of about 1,600 cases in the system all the time, going through.

Q33 Rosie Cooper: So you would suggest you have 1,600 cases on the go now.

Evlynne Gilvarry: Yes. That is our steady state; that is our normal inventory.

Q34 Rosie Cooper: We cannot establish a figure, but we have the 750 that you said you had cleared through the initial stages. How do you determine whether a case is in a backlog or in the current process? From looking at the evidence we have, a median time from complaint to final determination could be something like 90 days—sorry, I mean 90 weeks.

Evlynne Gilvarry: How do we determine it? As I said, the resources we applied to the 750 cases in 2014 were to clear a backlog, so that we would end up with what we call steady state, an inventory we can manage, and if I may—

Q35 Rosie Cooper: But you do not know how many you have. The question is: how do you define what a backlog is?

Evlynne Gilvarry: But we do know how many we have.

Q36 Rosie Cooper: Tell me what the number is.

Evlynne Gilvarry: I told you we have an inventory of about 1,600 cases all the time. The backlog of 750 cases was on top of that. That has now cleared its way through most stages and will be cleared through practically every stage by April, so we are very close to our steady state. That is being able to manage an inventory of about 1,600 cases, but we are not meeting all our KPIs at every stage yet. That is our aim: by the end of this year, we will be meeting as many of those KPIs as possible. That is the state we are in. We are moving toward it. We are going in the right direction. I am very confident of that, and the clearing of the backlog is a major step forward as part of that.

Q37 Rosie Cooper: Would you supply to the Committee your current state of play—the number of cases at each stage that you currently have today, please?

Evlynne Gilvarry: Yes, of course.

Q38 Rosie Cooper: Because we are not going to get any further with that. The High Court judgment said that the cost of clearing the backlog could not in itself justify the annual retention fee increase. Was the cost of clearing the backlog not part of the reason for increasing the fee?

Evlynne Gilvarry: Of course it was, but the backlog was part of an overall case load for fitness to practise that is extremely expensive to manage. We now have 3,000 cases every year. The additional investment was to make sure that we were able to deal with those effectively, and by effectively I mean meeting our KPIs at every stage of the process. That is what the investment is in. The backlog was one part of that, and clearing the backlog helps us to be able to deal with those 3,000 cases. But we have a very large case load and there is a cost to that; it is a cost we would hope to reduce if we get better legislation.

Q39 Rosie Cooper: You are saying that the old legislation you operate under is responsible for you reputationally being seen as possibly the worst regulator.

Evlynne Gilvarry: No, I would never suggest that. I do think, however, that the outdated legislation is holding back all regulators, and I mentioned a little earlier that our legislation happens to be a bit more antiquated.

Q40 Rosie Cooper: What part of the responsibility do you have for your poor reputation?

Evlynne Gilvarry: I take complete responsibility for the performance of the organisation. We have been working through pretty difficult and challenging times. We are steering the organisation through those and out the other end. The additional investment that will be allowed as a result of the greater ARF is very much part of that.

Dr Moyes: One also has to turn a spotlight on the previous council and ask questions about the wisdom of four years of no increase in fees, of eating into reserves and of not investing

in the infrastructure—the capacity and capability needed to handle these quite complicated fitness to practise cases. There are lots of things that should have been done differently, but I would not want you to overlook the fact that the previous council’s approach may not have been very wise, with the benefit of hindsight.

Q41 Rosie Cooper: Absolutely. Who would, if you like, almost pass judgment on the previous council each year, and who would pass judgment on your stewardship? How would you see that, if not in the reflection of the people who pay the money as well?

Dr Moyes: The PSA is the body charged by Parliament with taking a look at the performance of all the professional regulators and assessing whether they are up to standard or not. Undoubtedly, we have not been up to the standard that we should have been.

Q42 Rosie Cooper: So they have not been doing their job for the last four years.

Dr Moyes: I did not say that. Sorry, who have not been doing their job?

Q43 Rosie Cooper: If the council was not doing as well as it should do—

Dr Moyes: Are you saying the PSA have not been doing their job? I did not say that. I said the PSA had been looking at us and had been saying about us, “Your performance is not as good as it should have been.”

Rosie Cooper: Fine.

Chair: We are going to come on to a group of questions specifically about the PSA.

Rosie Cooper: That’s fine; I’m not going to get any further with that. Thank you.

Q44 Andrew George: On the attitude of the PSA, Ms Gilvarry, while you have said that you are steering the GDC forward and upward and things are improving, in their evidence to us, the PSA said that they have identified a serious decline in the GDC’s already poor performance in fitness to practise, and weaknesses in its registration process. They also said that it is certainly among the weakest of the eight regulators that they oversee. In relation to the length of time, which was one of the areas of concern, can you explain why performance is so poor? I know that to a certain extent this has been addressed, but the PSA’s evidence, which no doubt you have been looking at, does at least give us a benchmark to compare the GDC with other regulators. It is not performing well and it does not appear to be getting any better.

Dr Moyes: Can I make a general point and then I will ask Evlynn to talk in more detail? The PSA’s process is an audit process. It looks back at a cohort of cases, some of which, in the case of the most recent audit report, will have been started in 2012 perhaps, so they are old cases. That kind of audit report, as with any audit system, does not pick up rapid change. Given that the GDC is changing very rapidly, the cohort of cases that the PSA has looked at does not, and cannot, reflect that. I think the PSA—Harry Cayton—would

acknowledge that. That is just a point to bear in mind about the overall process. Do you want to talk about the detail, Evlynnne?

Evlynnne Gilvarry: The audits you are talking about looked at the initial stages of fitness to practise, our most problematic area. That is the early stage, which handles the greatest number of cases, and the last two initial stages audits showed all the signs of an organisation struggling to cope with a very large increase in complaints. That is not an excuse but it is an explanation for it. The fact that our performance had not improved—in fact it declined slightly over one year—is again very much due to the fact that the second audit came just some months after the first one and was sampling in the same pool of cases that were opened at about the same time. In fact, only a tiny fraction of the samples taken in the second audit were not already opened at the time of the publication of the previous audit. What we did in 2014, as you would expect, was literally to take every part of the PSA's report and every deficiency, and put in place an audit—our own compliance audit—of live cases, applying all the criteria on a week-by-week basis that are applied by the PSA. We are seeing real results through very robust performance management. Turning around a fitness to practise process, particularly when you are dealing with large case loads, is not a quick business, but in due course I am confident we will see a reflection of those results in a published external report. We are already seeing them ourselves, as I think was expressed in our memorandum to you, on a week-by-week basis.

Q45 Andrew George: But we are still talking about a period during the last four years, while you have been steering the organisation, so you cannot say that this is a period before you had any influence on the organisation. That would be running away from your responsibility, would it not?

Evlynnne Gilvarry: No, quite the contrary. I was absolutely not saying that. What I was saying was that in 2012-13 we got a very good report from the PSA. The initial stages audit at the end of—

Q46 Andrew George: But it has been on the decline. They said there was a decline in the outcomes.

Evlynnne Gilvarry: If I can explain, when I first joined the organisation, the report that the organisation had just received was not good. We had two years of improvement during which we started to see real results, reflected in the PSA's reports. The initial stages audit of 2013 was the first report that reflected a decline in the initial stages. It was not our performance overall; it was the initial stages of fitness to practise cases. I take full responsibility for that. That, as I said, was a reflection of an organisation struggling to cope with what was by any measure an enormous case load at that time. We had other kinds of issues. We had difficulty retaining caseworkers. Caseworkers were handling case loads that were demonstrably too high for a period of time. We put that right in 2014. We reduced the case load of individual caseworkers. We introduced much more robust performance management, and, as I said, we are already seeing that reflected in our internal audits.

Q47 Andrew George: You say that you are coming through the difficult period, so let us say for the sake of argument that we will accept that you are steering things through and reducing the delays in the investigations, but if one is looking at the recent past and what the PSA have been reviewing, one would expect that case closures and the quality of the investigations that have been undertaken would be improving now, and they have not found that. In fact they have been rather critical of the high level of errors made and, as they describe it, “Inadequate investigations and inappropriate case closures.” That would be in the period that you are describing as having been a period of improvement.

Evlynnne Gilvarry: I accept the outcome of the audit, but I am saying that that audit was sampling historical cases that had already been opened.

Q48 Andrew George: But the case closures are the latter stages, not the opening stages. The case closures are during a period of quality assessment that is during your period of office, your responsibility.

Evlynnne Gilvarry: Completely accepted, but I think we are talking about the initial stages audit where the PSA takes a sample of cases that were closed at the initial stages—because you do not have to wait until the end—but they may have been open two years prior to that. Their audit of 100 cases took a sample of cases, the majority of which related to a time when the improvements that we had effected in 2014 did not have an opportunity to show through.

Q49 Chair: Thank you. Could I turn now to look at things from the patients’ perspective and follow up on the comments from the Office of Fair Trading, following their market study in 2012 where they made several recommendations to the GDC? Could you comment on what steps the GDC has taken to ensure that dentists display prices correctly, perhaps providing written treatment plans, and how are you monitoring compliance and using your powers to make sure that that happens? Who would like to answer that?

Evlynnne Gilvarry: In 2013, we launched new standards. The standards specifically touch on that point. They are very stark about the responsibility of all dentists to display pricing. We launched those in 2013 with some fanfare and promotion, and we continued to get the word out through registrant newsletters, our own *Gazette* and so forth. Quite clearly, the Which? report shows that not every dental practice is displaying pricing and being transparent about it, so for 2015 we are already rolling out a number of activities aimed at reinforcing the importance of displaying pricing. We are also working with the Care Quality Commission, which incidentally inspects practices and is in a position to be able to identify if pricing is not displayed. However, the CQC does not inspect many practices, so we cannot rely on that. Working with patients, we are encouraging them to be alert to the importance of displayed pricing. We have a patient panel of 5,000 patients, representative across the UK. We have just embarked on a piece of research with two cohorts of patients, one of which has an upcoming dental appointment, and another cohort that has had unplanned treatment over the last two months, and we will record their experiences of the dental treatment received overall, including whether or not they noted pricing in practices. That is one example where, hopefully, we are working with the profession on the one hand and patients on the other to reinforce the importance of transparent pricing, because we know it is a problem. Unclear communication about what

is and is not available on the NHS, and in what circumstances, is a problem that recurs in our fitness to practise case load.

Q50 Chair: Will that study include written treatment plans as well?

Evlynne Gilvarry: Written treatment plans?

Q51 Chair: Yes. Wasn't having treatment plans for patients another recommendation?

Evlynne Gilvarry: Yes.

Q52 Chair: Will you also be looking in that study at whether people were given written treatment plans?

Evlynne Gilvarry: Yes.

Q53 Chair: Sometimes people might not notice that there is a display about pricing on the wall, but they would be more likely to notice whether they had been given a written treatment plan, presumably.

Evlynne Gilvarry: Sure.

Q54 Chair: Are you suggesting that this is something the CQC should primarily be responsible for?

Evlynne Gilvarry: No, I don't think so. I mentioned the CQC simply because it inspects practices and we do not have the power to inspect, but we have to be realistic: the CQC has recently made it plain that it will inspect no more than 10% of practices every year, so one could not place reliance on that.

Q55 Chair: If a patient wrote to you and complained that they had not been given a written treatment plan, and that they had looked in the surgery and could not find any evidence of a display of prices, what action would you take as the GDC, or would you step back from that and suggest that they contacted the CQC?

Evlynne Gilvarry: Gosh, no.

Q56 Chair: I am wondering what action you would take. That is my question. It is genuinely a question, rather than a criticism.

Evlynne Gilvarry: Indeed. If a patient comes to us with that kind of concern, we would immediately look to see how we could help the patient. First of all, it would go into our triage system. It would be one of those cases where we would ask the patient, "Have you asked your practitioner for the information?" But one way or another, if the answer was

no, we would take the case, investigate and see what the deficiency was. It is likely that we would end up reminding the practice of the standards, and the need to observe the standards in this case unless there was something obviously missing.

Q57 Chair: Your action would be to remind an individual practice of their responsibility to comply.

Evlynne Gilvarry: That would be a proportionate response in relation to that kind of concern.

Q58 Chair: But I think the point from the OFT was to ask the GDC what your role is in helping to shift the curves so that this becomes standard practice.

Evlynne Gilvarry: Exactly. That is what I was trying to describe a little earlier. There is a culture change needed about transparency of information within dental practices. If I may say so, this is a classic case where the regulator can work with professional bodies representing dentists to get the word out, to reinforce the importance of getting transparent information out there, informing the patient. It is all very much part of informed consent at the end of the day—to make the patient fully aware of the treatment they are receiving. It would be my appeal to the professional bodies to take this to heart and work with us in order to do that.

Q59 Chair: But you do not feel you are there yet. Would you agree?

Evlynne Gilvarry: I do not think so. You could not conclude that we are, because the Which? results were pretty stark in that regard. There is a good deal of good practice out there, absolutely, and we are aware of that, and patients occasionally write and tell us that they had a very good experience. We will learn a lot more from our patient panel, which will be our ongoing barometer of patient opinion. We will sample that—we will use it—to see whether or not patients really feel the difference in culture, but we are looking at the need for quite a shift in the culture within dental practices about the importance, and in fact the great benefit, of getting more information out to patients.

Q60 Grahame M. Morris: Can I press you on that point? You mentioned working with other organisations and so on. Specifically, what is the regulator doing to ensure that dentists do not mislead patients, particularly in relation to their NHS entitlements? Do you wait until you have received a complaint or a referral or, more generally, are you writing to practices indicating what their obligations are?

Evlynne Gilvarry: If you saw our standards, which have been sent and promoted to every dentist—every dentist has one and we also have an online version and an app for one, so it is entirely consultable at any point—you would understand that they are very stark on the question of the obligations of dentists to explain pricing, what is available on the NHS and what is available privately.

Q61 Grahame M. Morris: Just so that I understand it—perhaps you answered it earlier, but just for my information—that is what you would do to inform dentists of their obligations. How do you then monitor compliance?

Evlynne Gilvarry: You raise a really big question. To a large extent, we have to rely on patients bringing to our attention the fact that there has not been, or there may not have been, compliance. You are absolutely right: we do not have the power to inspect practices—we are not in practices, therefore, in that intrusive way. I think, however, that a culture change is happening. We are providing more information to patients about what their legitimate expectations should be, and our patient panel will help us to do that. Correspondingly, as I said, it is in the profession's interest—it is to their benefit—to put more information out there, so I would ask the professional bodies to reinforce that message, alongside us. The BDA is one example. Thirdly, most of the dentists we are talking about provide dental care on the NHS. There is a real role for NHS performance managers to make sure that the obligations of being on the performance list are observed. One of those obligations has to be to meet the standards of the GDC. I think we are looking at several different levers to bring about this difference in approach.

Q62 Grahame M. Morris: Okay. Thank you for that. Again, you touched on this in response to some questions from my colleague at the opening of the session, but in terms of the numbers of complaints that the regulator is receiving, how many of the ones that eventually go on to fitness to practise cases relate to things like poor communication, poor information about pricing, transparency issues and the lack of provision of a written treatment plan? How many relate to those, roughly, in percentage terms rather than the quality of the work?

Evlynne Gilvarry: About 65% of our cases relate to clinical matters, and the remainder relate to other matters. However—and other regulators will tell you this—somewhere in most complaints some deficit of communication features. It is why when we revised our standards we put in a whole new section, much clearer, about the obligations to inform patients. One of the other drivers, of course, is that patients are asking more questions, so there is a demand—a pull—from patients for that information. It is a continuing effort that we will all have to make. It is not just for us; it is for all parties involved.

Grahame M. Morris: Thank you.

Chair: Do you have any follow-up points on that, Rosie?

Q63 Rosie Cooper: I wonder whether the GDC would welcome revalidation for dentists, and whether that would help you address the communication, the pricing transparency problems and things like that. Do you think that would address the matter? Would you welcome revalidation of dentists?

Evlynne Gilvarry: We welcome anything that gives greater assurance about continuing fitness to practise. Essentially, providing the kind of information that you have discussed is a key component of being fit to practise, so the answer to that is yes. We are on a journey towards revalidation—a term that is now more used in relation to medical revalidation. We talk about methods of assuring continuing fitness to practise, and along that journey, we are just about to approve a new scheme of enhanced continuing

professional development, which will form a significant core of the requirements for continuing fitness to practise. Part of that will reinforce our standards. There will be a direct link between the obligations for continuing fitness to practise programmes and our standards. Of course, as I mentioned to your colleague, communication is writ large in our standards. If I had a copy here, you would see the starkness of the language in relation to it. Yes is the answer. I should say, however, that a full-blown revalidation scheme will take new legislation, and there are also other considerations, like investment by the NHS if we were to adopt a model that is applied to doctors. Most dentists do not have appraisals unless they are working in a hospital setting, so we would need to adopt a model of revalidation that was bespoke for dental practice as distinct from some of the other health professions.

Chair: Thank you. We are going to come back to the issue of local resolution.

Q64 Robert Jenrick: The median time to resolve a complaint is 89.9 weeks at the moment. Before we move on, what is your forecast for that figure for 2015? I think members of the public would be interested, because that is quite a shocking figure. If it was 100 weeks in 2013-14, in 2014-15 is it forecast to be 89.9, and what does “good” look like?

Evlynne Gilvarry: If I can relate it to months for each stage, our KPIs are 10 days for triage to conclude all cases, and we are already meeting that. From assessment to an IC hearing, it is six months from date of receipt. We are not meeting that in all cases, but in the very significant cases, and by the end of this year, I would expect to be meeting that target to get cases to the investigating committee in six months. As a result of the additional hearings we are running this year, we ought to be able to meet, in a majority of our cases, the target of nine months from an IC referral—investigating committee referral—to a first final hearing. I would be confident that the measures we have put in place will enable us to meet the two key KPIs, the six months and the nine months, in the majority of cases by the end of this year.

Q65 Robert Jenrick: Okay. Trying to help you, one element is trying to ensure that, where appropriate, people resolve their disputes at a local level, and the evidence we have received appears to demonstrate that that is one of the causes of your problems—so many complaints are not being dealt with at local level that people are perhaps resorting to you unnecessarily. We had evidence from the East Anglian local dental committee who said that they had seen a large number of complaints being received directly by the GDC from members of the public and it had actually increased. One of the explanations was that the number of staff who might have handled complaints at an area level had reduced in 2013-14, and that, once the GDC receives a complaint, legally you cannot pass it back down the chain; you have to look into it. What is your view on that? Have you seen that phenomenon nationally?

Evlynne Gilvarry: There is quite a bit of anecdotal evidence of that kind going around. We can only surmise—and it is surmise—that some of the changes within the NHS have caused a depletion of the previous performance management arrangements, the effect of which has seen a greater number of cases coming to us. However, as I mentioned earlier in the evidence session, we are not sitting by and just wringing our hands about this. We have, with the co-operation of five enthusiastic local area teams, established pilots to

assess the category of cases that would be more proportionately handled under the NHS performance management framework. We started the pilot at the beginning of this year. It will run for a year and we will do 15 cases in each of those areas. The intention is to try to identify quite a category of cases that could be handled in that way. It does of course assume that the arrangements will be adequate on the ground, and we have great co-operation with the five area teams. Logically, we would hope to roll out a scheme nationally.

Q66 Robert Jenrick: Do you think you have the legal powers you need, effectively, to be able to ask somebody if they have exhausted all the local routes before you accept their complaint and then put it into your own complaint handling process?

Evlynne Gilvarry: Yes, we do, but you can understand our nervousness about simply sending a case back without some kind of understanding that this concern may not be—

Q67 Robert Jenrick: But is the question “Have you exhausted the local complaint handling mechanisms?” asked before you formally accept receipt of a complaint at the GDC?

Evlynne Gilvarry: Yes, it is. Up to 30% of our cases are closed at triage. Some of those would come into the category where we had asked whether or not they had raised it with the practice. They may say no and then they go back.

Q68 Robert Jenrick: What sort of percentage, roughly, of complaints would be closed on those grounds?

Evlynne Gilvarry: Between 25% and 30% of cases overall are closed at triage.

Q69 Robert Jenrick: Within that category, how many would be closed because you had recognised that this could be resolved at a local level?

Evlynne Gilvarry: I do not have that percentage today. It would be a small number.

Q70 Robert Jenrick: Would you be able to give that to us?

Evlynne Gilvarry: Yes, I am sure I can. We are talking now about cases that come into our fitness to practise process. We mentioned earlier our non-statutory Dental Complaints Service. Routinely, cases that come in there are referred back if that conversation has not taken place, and it is only if there is a failure to resolve at that point that the DCS will take it on. But the idea that we do not have that conversation with patients in our fitness to practise process is wrong. However, if a patient is determined to complain to us, we cannot say no—that we will not accept their complaint. When they come to us, many patients have reached the point—I expect it is why the numbers will be quite low—when they are really quite fed up and they do not feel they can go back to the practice.

Q71 Robert Jenrick: Can I press you on that? We have received evidence from Dental Protection arguing that the GDC does not, perhaps due to a training issue within the organisation, apply the correct statutory tests to complaints and that there are, shall we say, inefficient processes within the GDC that result in excessive numbers of cases being referred to the IOC. Is that a situation that you recognise?

Evlynne Gilvarry: I do not recognise the fact that there is an excessive number going to the IOC. The interim orders committee is a committee that takes emergency action, essentially, if a caseworker says, “This is something that poses a real risk to patients.” The defence bodies may think we are referring matters that ought not to go to the IOC, and they are entitled to their view, but these are cases—

Q72 Robert Jenrick: Do you think the level of training is sufficient among your staff? If I could give you one example, Dental Protection’s evidence argues that there were inappropriate referrals to the GDC’s other committee, which examines dishonesty, because, due to a lack of training, there was, in their words, “an apparent lack of understanding of the dental professional environment. Our view is that to raise an allegation of dishonesty against a professional person is very serious, and the GDC has been misguided in its approach to the assessment of fitness to practise cases at the very early stages.” Do you think you are training your case handlers and staff sufficiently?

Evlynne Gilvarry: Our training is continuous and I would never be complacent about the need for it, or that it is entirely adequate quite all the time. It is a continuous process. That is happening. The defence bodies’ position on this has to be seen in the context of the work they do. Do we refer all matters on a charge of dishonesty to the investigating committee willy-nilly? Of course not—absolutely not. The defence bodies would argue that some of these are just mis-claims, administrative errors. Of course this can happen. Mistakes can happen. I am not saying that every charge for dishonesty before an IC was justified, but if we get it wrong, the investigating committee is an independent panel and it can make up its own mind based on the evidence before it. We work closely with the defence bodies and they have their job to do. But we have to make sure that if we see a matter that is sufficiently serious to refer to an interim orders committee because we believe there is a current risk to patients, we must do that. If we think that the pattern of complaining about a practitioner suggests dishonesty, it will be a charge of dishonesty. It is the defence bodies’ job, of course, to defend the people who are charged. We are not complacent about the stress caused by these allegations. We have serious guidance on allegations for our caseworkers, which has just been refreshed. I hope that gives you some reassurance that we are alive to the issues.

Q73 Robert Jenrick: You are comfortable that your staff are sufficiently trained to differentiate between cases.

Evlynne Gilvarry: What I am comfortable with is that we have continuous training—

Q74 Robert Jenrick: That is not the message coming from the evidence we have seen, certainly not from Dental Protection.

Evlynne Gilvarry: As I said, Dental Protection has a job to do. I am saying that, without being in any way complacent about the calibre or the competence of staff, it is a continuing process; our training is continuous. Most recently on the question of charging dishonesty, as that example was raised, we have refreshed our guidance on the listing of allegations for staff, and that is available to all our caseworkers and will be reinforced as part of our training.

Chair: Thank you.

Q75 Grahame M. Morris: This is an issue that my colleagues Rosie Cooper and the Chair touched on earlier regarding the impact of media advertising. I must ask, for the record, what your views were on the impact of the national adverts. I know, in mitigation, that the chief exec told us that they were designed to highlight the regulator's work, but they resulted in an increase in the number of complaints. Wasn't that completely predictable in terms of the impact of such an advert?

Dr Moyes: Can I start and perhaps Evlynne can come in afterwards? It is important to remember that the adverts that we placed were about the Dental Complaints Service.

Grahame M. Morris: I understand, yes.

Dr Moyes: And that is about patients' rights in relation to dissatisfaction about privately funded care. The council discussed this and it was a council decision to do the adverts. The council simply wanted to be sure that patients who were treated privately, who had paid for their own treatment and were dissatisfied, understood that there was an alternative to a fitness to practise complaint, and it was the Dental Complaints Service.

Q76 Grahame M. Morris: Is that local resolution?

Dr Moyes: Yes, in effect. It is a conciliation system that is very quick.

Q77 Grahame M. Morris: Perversely, on reflection—it is easy to be wise with hindsight, isn't it?—did that tactic undermine the efforts of local resolution by generating more complaints and so on?

Dr Moyes: No. There are two different issues there, if I may say so. Do you want to say a bit more, Evlynne?

Evlynne Gilvarry: It is the difference between our non-statutory scheme, the DCS, and the statutory scheme. If anything, more prominence for the Dental Complaints Service should stop matters that might otherwise drift to the fitness to practise process showing up there. One of the things that caused greater prominence for this advertising campaign was the timing of it. It looked like a provocative act. It certainly was not. It was a long time planned. We have promoted the Dental Complaints Service routinely using different media over time. It is a good service. We believe that it is important, particularly because the service deals with complaints that often involve elderly people—people who do not have teeth.

Q78 Grahame M. Morris: Absolutely. The purpose of these annual accountability hearings is, obviously, to hold you to account as the regulator, to look at your performance and see what lessons can be learned for the future in order to improve performance so that it is better for dentists and patients. You mentioned the timing issue. On reflection, are you still of the view that placing that national advertising campaign was a good tactic, even accepting that it was advertising the Dental Complaints Service? Might it not have been a predictable, if perverse, outcome that it would generate complaints and fitness to practise cases?

Evlynne Gilvarry: I think there is a lesson to be learned, but—

Q79 Grahame M. Morris: Even with the benefit of hindsight, you do not think that it had an effect.

Evlynne Gilvarry: Indeed. In hindsight, there is definitely a lesson to be learned, but I do not think it is quite the one that you are alluding to. It did not result in any increase in complaints; it simply did not. What it did, though, was to serve as a lightning rod for the anger of the profession. It looked provocative, and I am sorry; it was not meant to be that way. The ad was booked many months in advance. For us, it did not seem in any way unusual; it was just part of a series. It came out on that Sunday. The timing was viewed by others as being quite wrong, and I accept that that is how it came across. I am really sorry that it came across that way, but interestingly the feedback from the profession about that showed a great deal of misunderstanding on their part about the difference between our fitness to practise work on the one hand and the DCS on the other. We used the opportunity, as a lesson learned, to do our best to try to draw the lines and make that clearer.

Q80 Grahame M. Morris: I have a suspicion that many dentists will disagree with you, but that is your position as the leaders of the organisation and it is duly noted. Thank you.

Evlynne Gilvarry: I should say, however, if I may, that there is a very high level of support from the dentists within the profession for the DCS—a very high level of support. If you look at the satisfaction surveys for those who are complained about—the dentists mostly—they are similarly satisfied with the service. I think the DCS gets the dental profession's vote, mostly. I do not think the ad did, though; I accept that.

Grahame M. Morris: Yes, but you are kind of conflating the issue about the national advertising campaign and the Dental Complaints Service. I do not think anyone is complaining or raising concerns about the validity of the Dental Complaints Service; it was just the way it was done, the timing and the way it was perceived. The Committee notes your answers, I am grateful for them and we will move on.

Q81 Chair: Thank you, Grahame. Could we come to the interpretation of standards? Perhaps, Dr Moyes, you could answer this question. In determining the outcome of fitness to

practise hearings, are dentists being judged against the standard of best practice or against acceptable standards of practice? Could you elaborate on that?

Dr Moyes: I am not in a position to answer that question very reliably because the council does not get involved at that level of detail in fitness to practise, so if you would not mind, I would rather Evlynne pick that up, Chair.

Chair: Of course.

Evlynne Gilvarry: There are two kinds of standards. There are the standards of practice, the requirements we issue—standards of behaviour, dealing with informed consent and information for patients, all of that. That is one set of standards. We are very clear about that. They are unambiguous and, frankly, non-negotiable. We think they are set at the right level. What you may be referring to is a charge that is frequently made—or occasionally made—by the defence bodies that the bar for clinical practice, clinical standards, is set too high.

Q82 Chair: Indeed, I am talking about that. You will be aware of course that the Faculty of General Dental Practice submitted evidence to us where they say that they feel it is often interpreted incorrectly and that is resulting in flawed assessments.

Evlynne Gilvarry: I have seen that, but let me explain. Roughly 65% of our cases now relate to clinical matters.

Q83 Chair: Was that 65%?

Evlynne Gilvarry: Yes, roughly—between 60% and 65%, that sort of thing. When we get a complaint of that kind, more often than not it is clear to us that we need to get a clinical view on it early. We have a contract with NCAS, which has a panel of—

Q84 Chair: For people following outside the room, could you say what NCAS is?

Evlynne Gilvarry: It is a service that looks at standards of practice, health care practice, and in relation to dentists it looks at the performance of dentists. It will do a review of the performance. The contract that we have with them is through a panel they have compiled of general practitioners and specialists who enable us to take a view, get an early clinical opinion or view—it is not an expert witness, not that kind of opinion—as to whether or not the treatment offered was reasonable in the circumstances. To aid that view the practitioner will have the records—the complaint and the clinical records. Initially with NCAS we had a set of standards, which are “meets the standard”, “falls below it” and “falls well below”. We have recalibrated that in the light of some feedback. I am confident that clinical matters are referred to practitioners who do that kind of work, and I am also confident that, by and large, the standards set are reasonable in the circumstances. Practitioners often disagree on that, but some of these cases will go forward to the investigating committee. That is an independent panel that will take other considerations into view as well.

Q85 Chair: But at that panel, that is the crucial point, isn't it?
Evlynne Gilvarry: Yes, it is.

Q86 Chair: Is it a best practice standard or an acceptable practice standard? Could you be clear on where you set the bar?

Evlynne Gilvarry: The investigating committee will look at the circumstances in the round. The report from the NCAS specialist, or general practitioner, will just be one part of it. As I understand the point being made by some defence bodies, it is the NCAS report that sets the standards so high. We have recalibrated that recently. We are confident that, by and large, the standard is being set at the right level. The faculty makes a slightly different point. It has best practice standards, and its view is that expert witnesses are applying those standards; it raised this point with us relatively recently, and we are looking into it. I think it is expert witnesses they mean rather than the NCAS advisers. We have no evidence to suggest that those particular standards are being applied, but we are looking into it. We have committed to the faculty to get back to them on that point.

Q87 Chair: Do you feel that there is sufficient consistency, or do you think it will vary? In other words, it is difficult for dentists to know what the bar will be.

Evlynne Gilvarry: Yes. Consistency is very important and, as you might expect, when we are in negotiation for the contract with the NCAS panels, it is a continuing theme. They have their training, and we have days with them so that we can look at issues like consistency. But it is worth pointing out that the NCAS report is only one part of a range of evidence that comes before the investigating committee; it does not drive everything.

Chair: Thank you. Now we come to case examiners.

Q88 Charlotte Leslie: First, my apologies for being late and, secondly, my apologies if in my questions I cover anything that has already been covered. Before I come to case examiners, with the Chair's indulgence, I have a couple of points I would like to ask you about. Again, I am sorry if they have been covered. I note you said that the DCS has a high level of support from the dentistry profession. That does not chime, as you will understand, with quite a lot of the evidence that we have received. Where does that evidence come from, and will you be able to submit it to the Committee for a balanced report into the evidence we have received?

Evlynne Gilvarry: I would be happy to do that. The feedback we were talking about comes from dentists who were involved in the service and were the subject of a complaint. They show very high satisfaction ratings. Generally speaking, our understanding is that the DCS is well received within the profession and seen as a useful, proportionate method of resolving complaints—which, incidentally, are not fitness to practise complaints. It does not handle them: if there is an allegation of impaired fitness to practise, that must go to the statutory scheme.

Q89 Charlotte Leslie: Would you hear from those who were not satisfied with the scheme? Is it proportionate representation that you get in feedback?

Evlynne Gilvarry: We have not had that representation. We would be happy to listen to that view, but it has not been presented to us, no.

Q90 Charlotte Leslie: I would be grateful if you could submit that to us, and the scope of the feedback that comes in.

Evlynne Gilvarry: Of course, absolutely.

Q91 Charlotte Leslie: Secondly—forgive me for asking—the empathy and trust of the profession is vital in the role that you perform. I notice that you both have very impressive careers, but neither of you has been a dentist or had anything to do with dental surgery. Do you think perhaps you should, if the profession is to have trust that you understand what it is like to be a dentist and the issues that dentists face?

Evlynne Gilvarry: I do not think the fact that I am not a dentist or that the chairman is not a dentist is the issue. The most important thing is that we have access to the opinion of the profession—up to date and continuously—and we have that access in a number of ways. We need to understand continuously the changes in dental practice—changes that really meet the challenges that dental practitioners are facing. The best way we can do that is not by being dentists ourselves, but through recognition—I do recognise that—and continuous dialogue with dentists and the dental care professionals, who make up two thirds of the profession, to understand what practice is like on the ground, and also, on the issues that I was discussing just now with your Chair, when we need clinical advice. We will always need to go to the people who know what they are doing, and even if I was a dentist, frankly, I would probably have lost touch. I do not think there is a deficit of understanding, so long as we keep bridging it by ensuring that we have touch points for opinion right across the profession. The profession is changing, not very quickly, but there are very significant shifts, and we must be in touch with that.

Q92 Charlotte Leslie: Many might argue that the only way you can have real empathy with a profession and understand the actual daily workings of things is by doing—understanding by doing. There would be an argument that there is a unique brand of understanding that is needed for absolute empathy, and therefore understanding how the profession works. How many of your senior leadership team in the GDC have a dental background? I am not asking whether they are dentists at the moment, but how many have at some point worked as a dentist, so they understand the realm in which dentists are operating?

Evlynne Gilvarry: None of them is a dentist.

Q93 Charlotte Leslie: None of the GDC leadership team has ever been in dentistry.

Evlynne Gilvarry: No, but their understanding is part of our approach to leadership. We do not do anything—none of our activities gets off the ground—without consultation with the profession at every level. That is really important, because even if they were dentists,

understanding the need to consult and tap into opinion is the most important thing. If that were missing that would be a problem, but even if they were dentists it would be no substitute at all for—

Q94 Charlotte Leslie: How would you know what you did not know? You do not know what you do not know because you are not a dentist. It may be that dentists look at what you think is understanding, and I have no doubt at all that you do a very diligent job at your consultation, but epistemologically you would not know if you did not understand dentists; that is the very definition of not understanding. How certain can you be, and how satisfied do you think the dental profession is, that you understand the dental profession and empathise with them in that very grassroots way?

Evlynnne Gilvarry: That is a very fair question, but our understanding of the dental profession has to be driven by our statutory duties, and we are here for patients. Our core responsibility to protect patients drives us to develop that understanding of the dental profession in various ways. It may not be the most forensic, complete understanding of every feature of dental practice—of course not—but we take our steer from what patients tell us they want and what we perceive patients need, and we develop our understanding with the profession accordingly. We are a regulator, after all, so every piece of regulation we formulate has to reflect an understanding of current dental practice; of course it does. That is what drives our dialogue with the profession. I really do not think it is necessary to be a dentist, but it would be a problem if we did not have that level of awareness of the need to get the information to make good dental regulation.

Dr Moyes: The only point I would add, if I may, is that at the more strategic level of the organisation, of course, half the council are dentists or dental care professionals. I very much agree with Evlynnne on this: being a trained dentist or dental care professional does not seem to me to be a requirement to chair an organisation like this.

Q95 Charlotte Leslie: Finally, before I move on to the case examiners, when I came in I heard a phrase that I am afraid you will understand this Committee hears so often—“lessons have been learned” or “lessons will be learned”—that we begin to associate it with “lessons that will never be learned”. You have been chair for five years. How long do you think you can be in place before lessons are actually learned and people have faith that it is not just a constant kicking the can down the road, of things being better tomorrow? I am sorry to have to ask such a question. That was to the chief executive, I am sorry.

Dr Moyes: I have been chair for less than 18 months, or around 18 months, not five years, but one of the things that the council is very keen to understand is exactly as you say: what are the things that we should have done differently? That is why we have a major change programme going on in the organisation. We are reviewing all sorts of aspects of the organisation, and we are feeding into that the things we take from the criticisms that we have had that we believe are valid. But not all the criticisms are valid; some of them are based on misapprehensions. I think the organisation is changing very rapidly indeed, and I am quite confident that you will see that in its performance, and that is how you will know that lessons have been learned.

Evlynne Gilvarry: I have been chief executive for four years, and during those four years we effected some very significant changes. It was also when we saw our case load double over three years. We struggled—I make no bones about it—under that weight. We are catching up fast. We are learning an awful lot. We had a tough year last year. We had to go to the profession for additional money to fund the extra work. We have come through that. We have learned a lot of lessons and they are not lessons that are going to remain on the shelf. We have learned a great deal of them and we are going forward. We had a programme of significant change in 2014, we are going into another one this year and I do not expect 2016 to be any different, but we are determined that this is not going to be a “lessons never learned” exercise.

Q96 Charlotte Leslie: It is our job to ask difficult questions, so I do apologise.

Evlynne Gilvarry: It is quite okay.

Q97 Charlotte Leslie: Moving to the case examiners, is the purpose of introducing case examiners simply to contain the costs associated with fitness to practise investigations?

Evlynne Gilvarry: No, it is not—absolutely not—although that is a corresponding benefit; it will save us, we expect, up to £2 million a year. The primary advantage of case examiners is—going back to your earlier question—that when or if we get the powers, which we are very hopeful we will, it will be an opportunity for us to employ dentists and dental care professionals as case examiners, so we will have dentists and dental care professionals deciding cases within our staff.

Q98 Charlotte Leslie: Given that those individuals will have to be independent to have the trust of the profession, how do you see that fitting with the fact that they will be employed as staff?

Evlynne Gilvarry: It is distinctly possible; other regulators do it. The General Medical Council, which has had the powers to have case examiners for close on a decade now, does it, and you would expect—

Q99 Charlotte Leslie: If I may say so, there have been issues with the General Medical Council as well, so it is possibly not the best model to base your model on, in reality.

Evlynne Gilvarry: If I may say so, in relation to the General Medical Council and case examiners, they are an excellent case study for us because they have taken it through wave after wave of change; they have learned some lessons and are generously sharing their know-how with us about how to—exactly as you say—draw the boundaries and make sure that there is no interference with the independence of the individual making the decision. They are making decisions on behalf of the GDC, by the way, so there is no problem there, but we need to make sure that there is sufficient separation between the very early investigation work and the decision-making work. That will be made possible by putting in clear guidance for the people doing the earlier work, and also for the case examiners. But your fundamental point was about the purpose of it, other than saving money. The

purpose is that, working well, the case examiners will take many of the cases that currently go to the investigating committee. Necessarily, we have a six-month KPI—key performance indicator—from receipt of complaint to investigating committee. A good portion of that is taken up with investigating the case and getting it ready, but there is still quite a time lag in convening a schedule of meetings of the investigating committee. We are running four a week now. Case examiners will be able to handle those cases at an earlier stage, which is better for patients and better for those who are complained about. Also, because the vast majority of our cases are closed in the earlier stages, many of those cases will be closed with or without sanction. It is a very important change for us, and we really look forward to it. It is not simply for the economic advantage to the profession, because it is their money that we spend as a regulator.

Q100 Charlotte Leslie: Going back to the GMC model—it is commendable that you are looking at a model and not just starting from scratch—when we had the GMC in front of us, we had significant evidence of a lot of concerns about the way the GMC works as well, as you might expect from anybody. In bringing that model over to the GDC, are you looking at the issues or problems that the GMC has, as well as what it does well?

Evlynne Gilvarry: Of course. That is the whole point, and we have the great advantage of very free sharing of know-how with the GMC on that point. It is a very important comparator for us because the other regulator that has case examiners simply does not have the size of case load that would make it a really good comparator. Yes, we are learning very much from the GMC, and they share generously with us: what did not work, as well as what did work and vice versa.

Q101 Charlotte Leslie: What key lessons have you taken from the GMC? Everyone likes the benefit of hindsight and to start from a different point, but what are the key things you hope to do right that you feel the GMC, with the benefit of hindsight, could have done better?

Evlynne Gilvarry: Are you talking about case examiners?

Charlotte Leslie: Yes.

Evlynne Gilvarry: The reason I hesitate is that the scope of our powers—the ones we will get—has not been published yet. The Department of Health has not published that, so the true answer to your question will depend on the scope of the powers we are given. If we are given powers to agree undertakings, for example—case examiners with undertakings—there are many issues arising from that which I know have been live for the GMC. As I said, our section 60 order has not been published. We do not quite know what shape it is going to be. We hope it will come in any form, and when it comes out we will look at it afresh. If we get undertakings, we will have to develop really clear guidance for case examiners on their application, and that is where the GMC's experience can be most helpful to us.

Charlotte Leslie: Thank you.

Q102 David Tredinnick: I, too, am sorry I was not able to attend Committee earlier. I sit on the Science and Technology Committee as well, which was next door finalising a report, and our Chair, Andrew Miller, is retiring from Parliament after 23 years.

I want to ask you, if I may, first of all, Ms Gilvarry, a general question. You were chief executive and registrar of the General Osteopathic Council, were you not, before you joined the GDC?

Evlynne Gilvarry: Yes.

Q103 David Tredinnick: I imagine that might have been an interesting time because of the amalgamation of different groups of osteopaths. What lessons did you learn and what wisdom do you think you have brought to the GDC from your experience with the General Osteopathic Council?

Evlynne Gilvarry: On the issue of amalgamation, maybe you are thinking of the chiropractors rather than the osteopaths.

David Tredinnick: We won't get to that; we'll just leave it.

Evlynne Gilvarry: My experience at the General Osteopathic Council was rich in the following sense. The Government were just requiring all regulators to change their governance procedures, and I joined the General Osteopathic Council at the point when it was planning that change and making it, so I had that rich experience to bring to bear to the General Dental Council. The General Osteopathic Council has all the range of responsibilities of the General Dental Council, but the scale is different. There was a lot to do. It was a period of immense change, and when I left I hopefully took that experience with me and have applied it at the General Dental Council.

Q104 David Tredinnick: Thank you. I want to talk about governance, and then special investigations. It must have been disappointing, given what you said, when the Professional Standards Authority in written evidence to us said that, when they were looking over your organisation, your "performance was worse than seven of the other eight regulators we oversee". That is not a very good report.

Evlynne Gilvarry: No, quite clearly not. This is an issue we covered pretty thoroughly a bit earlier, but largely—

David Tredinnick: Yes, I am sorry I was not here.

Evlynne Gilvarry: It's quite okay. To summarise, the organisation was on a significant improving path up to 2012, at which point it started to show the pressures of dealing with a very large case load over a very condensed period of time. Yes, we struggled. One of the features of that was difficulty in retaining staff at that particular point in time.

Q105 David Tredinnick: I will deal with that.

Evlynne Gilvarry: We also started to have insufficient resources to deal with cases sufficiently quickly. Performance, therefore, as measured by the PSA, definitely slipped.

There is no question. When you look at the reports for 2012 and 2013, there is a big difference. It is explainable by the pressures the organisation was under. That is unquestionably the case, and we were not as well equipped as we could have been had we anticipated, as we did not, the very large increase in cases over such a short period of time. We are in a different position now. We have learned those lessons; indeed, we are working with the PSA. We have a programme of change right across the organisation, but very specifically in fitness to practise because the PSA's report showed that the standards slipped primarily in fitness to practise.

Q106 David Tredinnick: The evidence we have is that they conducted one special investigation, I think, and are now conducting another.

Evlynne Gilvarry: Yes.

Q107 David Tredinnick: The Professional Standards Authority said that the council “were not aware of the problems” which prompted their investigations. Do you know why that might be?

Evlynne Gilvarry: I do not think it says quite that. It raises the question. The council were aware at the point when the problems became evident to me and the audit and risk committee. The second investigation is not yet complete, and we have to wait for the outcome of that.

Dr Moyes: Generally, from the point of view of the council, one of the things we have put a lot of effort into is getting a better system for understanding and managing risk in the organisation and understanding the performance of the organisation. We now have dashboards for every part of the organisation, and the council looks at them regularly. We have detailed examinations of risk in the audit and risk committee and in the council, so we have substantially strengthened the extent to which the council understands what is happening in practice in the organisation.

Q108 David Tredinnick: Going through the evidence, it seems that part of the problem was the cosy relationships within the organisation. What assurance can you provide our Committee that the investigating committee decisions are made without inappropriate influence from elsewhere in the General Dental Council?

Evlynne Gilvarry: I hope I will be able to assure you on that point. We have made a number of changes. In response to a concern that was raised in 2013, I commissioned an independent investigation by an external law firm to look into concerns about what you call “cosy relationships”—working practices that could pose a risk to the independence of the investigating committee. The outcome of that—

Q109 David Tredinnick: Excuse me, but the specific allegation is the “holding of private discussions between the Investigating Committee’s secretaries and Chairs about individual cases prior to Investigating Committee meetings”.

Evlynne Gilvarry: Exactly. Arising from the report there was a series of recommendations that we have implemented rigorously, and six months after that—maybe nine months—we had a further report from the same independent lawyers who came to do a review to see whether or not the recommendations had been implemented fully. The team of lawyers interviewed all the parties involved and satisfied themselves in a report to the council that all the recommendations had indeed been implemented successfully and effectively. What, in essence, was required was a change of culture in that part of the fitness to practise department. We also needed some new people, and that has happened. We now have a new investigating committee in place, with as much support as I believe is important for an independent committee to guard their independence—

David Tredinnick: Restructuring.

Evlynne Gilvarry: With ongoing monitoring and training. I hope I can offer you assurance on that point.

Q110 David Tredinnick: Fine. Moving on a little, what about your own staff? What are you doing to support them if they wish to raise concerns about professional standards within the General Dental Council?

Evlynne Gilvarry: That is a fair point. Through a number of mechanisms, we encourage staff to raise their concerns if they have any. There is a whistleblowing policy, obviously, but we encourage a culture where any member of staff can speak up to their line managers in the first instance, to a director or directly to me. That is something very important to me. As a complete default mechanism there is a whistleblowing policy, which was recently revised and has been actively promoted to staff. But I like to work in and encourage a culture where concerns are dealt with at the point where no harm can have happened.

Q111 David Tredinnick: Fine. Where we are coming from here is that our previous accountability hearings, particularly those with the Nursing and Midwifery Council and the Care Quality Commission, identified poor staff morale, high staff turnover and excessive work loads as symptomatic of failing organisations. It is not just the General Dental Council that is under the spotlight. The spotlight has been shining into other corners—some very large ones too. Pursuant to your earlier reply, can you tell me if you have any figures for staff turnover in the General Dental Council, specifically within the fitness to practise directorate?

Evlynne Gilvarry: Sure. When I joined the organisation initially, staff turnover at that point was 33%. By two years on, it had been reduced to 12%, so that may say something about the culture that I try to embed in an organisation. The fitness to practise department, at the point where the case loads started to increase, definitely suffered from turnover of caseworkers, because for a period of time they were dealing with case loads that were too large to be feasible. We have taken down those case loads, and now staff turnover is perfectly within national norms; it is currently about 13% or 14%. An important point is that, even when we lose people from the fitness to practise department, it is usually to other opportunities within the GDC. Overall, we are regarded as a good employer with a good culture, but it is unquestionable that for a period of time we suffered from turnover in the crucially important area of casework.

Q112 David Tredinnick: What you are saying, I think—if I understand you correctly—is that the employees were given work, and it was like Charles Atlas holding up the world and the world came down on them because they were trying to do too many things.

Dr Moyes: The council had not increased their fees in line with the increased number of complaints, so they could not invest in more people.

Q113 David Tredinnick: That is what I was going to say. If you reduce the case load, presumably the cases have to go somewhere else. You are saying it was a resources issue.

Dr Moyes: We have invested in more people—two new teams. Off the top of my head, the figures used to be 70 cases per caseworker and it is now down to about 40. Those are the right orders of magnitude.

Q114 David Tredinnick: It is a huge difference, isn't it, as a burden?

Dr Moyes: It is a huge difference, and that is the result of the investment.

David Tredinnick: I'm sure you covered this earlier on, but there has been further investment, so more funds have come your way, and that has made life easier. Thank you, Chair.

Chair: Robert, you have a final follow-up point.

Q115 Robert Jenrick: Yes. I want to ask a final question about executive pay within the organisation. I notice that in 2013, which we have heard was—I don't know how you would characterise it—not a particularly successful year for the organisation, performance payments were made to three members of the senior team, presumably praising good performance, and you yourself as chief executive took a pay rise. Are you able to set out what your plans are for the annual report? Are performance payments being paid for staff—the senior team—for their performance in 2014? Do you intend to take a further pay rise, given that your salary is already more than the Prime Minister's, for a year that was not exactly successful?

Evlynne Gilvarry: My salary is benchmarked externally. I do not set it. It is set by the remuneration committee, and it is set by reference to an external benchmark. As for setting out my current plans for remuneration for staff, I have not had those discussions with staff, so I hope you will understand if I do not have the first discussion here with the Committee. As an organisation, we are very conscious that pay for performance has to be preceded by good performance. We have introduced a new pay structure this year, which is very different. Previously we had an incremental system of payment, which was far from ideal and simply not fit for purpose. The new system will positively reward good performance and that, coupled with a culture of performance management, which is very different from the past, will bring about a culture within the organisation where performance is rewarded, but it has to be really good performance. I hope I am answering your question sufficiently clearly.

Q116 Robert Jenrick: Do you think it was wise to give performance payments for good performance and to take a pay rise yourself in a year in which you were going back to the profession to ask for significant sums due to financial mishandling in the organisation?

Evlynne Gilvarry: I accept your question, but I think we are talking about different years. The year that the performance payments, which were quite modest, were made reflected performance in 2012, which was not a troubled year. In fact, it was a year when our PSA report was very good.

Q117 Robert Jenrick: I was looking at 2013.

Evlynne Gilvarry: Yes, but it follows—

Q118 Robert Jenrick: The pay rise would relate to your salary in 2013-14. That is when it took effect.

Evlynne Gilvarry: Yes. That was, as I said, independently benchmarked, because the previous salary was regarded as having fallen particularly far behind. It was nothing to do with me. What I am saying, though, is that at a time when we are improving our performance it follows clearly—it certainly seems sensible to me—that any reward for that must necessarily follow that improvement.

Robert Jenrick: I understand.

Q119 Chair: Thank you. The final question of the day is this. The Committee shares the GDC's disappointment that the Law Commission draft Bill was not taken forward, but it would be helpful to put on the public record, if it is not taken forward early on by the next Government, what measures you would like as a bare minimum to be taken through in regulations. Could you set out, and perhaps follow up in writing, what you would like to see as a minimum?

Evlynne Gilvarry: In writing.

Q120 Chair: Yes, but, if you want, you could set out a general overview now.

Evlynne Gilvarry: Exactly. I would be happy to, and thank you for the opportunity. As a bare minimum, in the immediate term we need the much talked about section 60 order that would give us case examiners, hopefully with a full set of powers. We have run out of parliamentary time for that. That requires the early support of the new Administration. Whatever happens, we need that early. That is a small change. As I mentioned earlier, case examiners are a change that the General Medical Council has had for a decade. If my colleague at the General Medical Council was here, he would say, "It's okay, but we, the General Medical Council, need change on a much greater scale." We also, as the General Dental Council, need that. My earnest hope is that, post-election, a new Government will take a step back and really look at the work that the Law Commission has done, which is very good work, but use the opportunity to design a new blueprint for professional

regulation. It is not just tidying it up; it needs something really quite fundamental. That is my bigger vision. If that does not happen, the draft Bill that the Department prepared based on the Law Commission's work, and where we have had full input, will make a big difference, we believe, so that will be fine. If that does not happen, we are in the very—in my view—untenable situation of a plethora of section 60 orders to give each regulator something to get them out of whatever their latest fix is, but that is hopeless; it is not a way to go forward. That is my vision. I would be very happy to write to you about it.

Q121 Chair: Thank you. Are there any final points you want to make, Dr Moyes?

Dr Moyes: These sessions are not meant to be comfortable and we understand that, but we welcome the fact that you called us to give evidence today, because it is important that you hear from us direct about the scale of things that we are trying to do, and the scale is large. I really believe the effect will be apparent very quickly, and perhaps if you invite us back in a few years' time, or a few months' time, we will be able to demonstrate that to you. Thank you very much.

Chair: Thank you for coming today.